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Anthem

Administered by Healthy Alliance Life Insurance Company

Your Health Benefit Booklet

HEALTH BENEFIT BOOKLET

Blue Access℠ PPO

Anthem Blue Cross and Blue Shield
1831 Chestnut
St. Louis, MO 63103
314-923-4444

BCBSMo-ASO PPO 06

1 INTRODUCTION

This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your health benefits. This document replaces and supersedes any Benefit Booklet or summary that you have received previously. Please read this Benefit Booklet carefully, and refer to it whenever you require medical services.

The Benefit Booklet describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Benefit Booklet are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Benefit Booklet.

This Health Benefit Booklet overrides and replaces any Health Benefit Booklet previously issued to you. The coverage described in this Benefit Booklet is based upon the conditions of the Administrative Services Agreement issued to your Employer, and is based upon the benefit plan that your Employer chose for you. The Administrative Services Agreement, this Benefit Booklet and any endorsements, amendments or riders attached, form the Administrative Services Agreement under which Covered Services are available under your health care benefits.

Many words used in the Benefit Booklet have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being stated.

If you have any questions about this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card.

2 MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

- Receive information about the organization and its services, practitioners and Providers, and Members' rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under your Plan and Schedule of Benefits;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under your Plan;
- Participate with your Provider in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services you received from a Provider, or the service you received from the Administrator, and to have the Administrator, on behalf of the Employer, investigate and take appropriate action;
- Call with a complaint or file a grievance with the Administrator, on behalf of the Employer:

  Anthem Grievance Unit
  P.O. Box 14882
  St. Louis, MO 63178-4882
  1-800-392-1104

- Privacy and confidential handling of your information;
- Make recommendations regarding the Administrator's rights and responsibilities policies; and
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Member, You Have the Responsibility to:

- Understand your health issues and be wise consumers of health care services;
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information the Administrator, on behalf of the Employer, needs to administer benefits and that Providers need to care for you;
- Understand how to access care in routine, Emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Coinsurance, Copayments, etc.;
- Notify your Provider or the Administrator about concerns you have regarding the services or medical care you receive;
- Keep appointments for care and give reasonable notice of cancellations;
- Be considerate of other Members, Providers and the Administrator's staff;
- Read and understand your Benefit Booklet and Schedule of Benefits, and other materials from the Administrator or Employer concerning your health benefits;
- Provide accurate and complete information to the Administrator, on behalf of the Employer, about other health care coverage and/or insurance benefits you may carry; and
- Inform the Administrator and the Employer of changes to your name, address, phone number, or if you want to add or remove Dependents.

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3 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Member's responsibility for Covered Services.

To receive maximum benefits at the lowest Out-of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider, you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any Deductibles, Coinsurance, Copayments, and non-covered charges.

Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

BENEFIT PERIOD	Calendar Year
DEPENDENT AGE LIMIT	To the end of the month in which the child attains age 19; or to the end of the month in which the child attains age 25 if the child is a full-time student enrolled in a state-accredited college, university, trade or secondary school on a full-time basis.
PRE-EXISTING PERIOD	For any Pre-Existing Conditions in existence 6 months **prior** to your Enrollment Date, the services, supplies or other care related to the Pre-Existing Condition(s) are not covered for 12 months **after** your enrollment; or 12 months after your enrollment if you are a Late Enrollee.

DEDUCTIBLE

	Network	**Non-Network**
Per Member	$0	$1,000
Per Family	$0	$3,000

Note: The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to all Covered Services with a Coinsurance amount you incur in a Benefit Period except for the following:

- Emergency Room services when subject to a Copayment plus Coinsurance
- Prescription Drug benefits

Copayments are not subject to and do not apply to the Deductible.

OUT-OF-POCKET LIMIT

	Network	Non-Network
Per Member	None	$4,000
Per Family	None	$8,000

The Out-of-Pocket Limit includes all Deductibles and Coinsurance amounts you incur in a Benefit Period except for the following services:

- Prescription Drug benefits
- Non-Network Human Organ and Tissue Transplant services

Copayments do not apply to the Out-of-Pocket Limit.

Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for the services listed above.

Network and Non-Network Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits are separate and do not accumulate toward each other.

The Deductible(s) apply only to Covered Services with a Coinsurance, excluding Emergency Room, allergy testing, and Prescription Drugs, received as a Network service. Prescription Drugs are subject to separate Deductibles and Copayments/Coinsurance amounts.

LIFETIME MAXIMUMS

	Network	Non-Network
Lifetime Maximum for all Covered Services	Unlimited	Unlimited

COVERED SERVICES	COPAYMENTS/COINSURANCE/MAXIMUMS	
	Network	**Non-Network**
Ambulance Services (Emergency)	No Copayment up to the Plan's Maximum Allowable Amount	No Copayment up to the Plan's Maximum Allowable Amount

Note: Emergency ambulance services will always be covered at the Network level.

Ambulance Services (non-emergency) Note: Non-emergency ambulance services will always be covered at the Network level.	No Copayment up to the Plan's Maximum Allowable Amount	No Copayment up to the Plan's Maximum Allowable Amount

Behavioral Health Services

Mental Health & Substance Abuse Services

Coverage for the Inpatient and Outpatient treatment of a Recognized Mental Illness is provided to the same extent and degree as for the treatment of physical illness.

Inpatient Services for Recognized Mental Illness or Substance Abuse services	$250 Copayment per visit	30% Coinsurance
Outpatient Services for Recognized Mental Illness or Substance Abuse services	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance
Medical and Social Setting Detoxification up to six days per Calendar Year	$250 Copayment per visit	30% Coinsurance
Physician Home Visits & Office Services for Recognized Mental Illness or Substance Abuse services	$15 Copayment per visit	30% Coinsurance
Substance Abuse Episodes: An Episode is defined as a distinct course of Substance Abuse treatment separated by at least 30 days without treatment.	10 Episodes per lifetime for Inpatient and Outpatient services, Network and Non-Network combined	
Inpatient Substance Abuse Services through a Facility-Based Treatment Program, days per Benefit Period	30 days, Network and Non-Network combined	
Outpatient Substance Abuse Care through a Facility-Based Treatment Program, days per Benefit Period	30 days, Network and Non-Network combined	
Physician Home Visits & Office Services for Substance Abuse Care, visits per Benefit Period.	30 visits, Network and Non-Network combined	

Dental Services (only when related to accidental injury or for certain members requiring general anesthesia)	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received

Diabetic Equipment, Education and Supplies	For information on equipment and supplies, see "Medical Supplies, Durable Medical Equipment, and Appliances". For information on diabetic education services, see "Physician Home Visits and Office Services". For information on Prescription Drug coverage, see "Prescription Drugs".	
Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services, the Copayment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and or tests, including services received at an independent Network lab, may not require a Copayment/Coinsurance. Laboratory services provided by a facility participating in the Administrator's Laboratory Network (as shown in the Provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory that is not part of the Administrator's Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.	

Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Emergency Room Services Copayment/Coinsurance is waived if you are admitted	$50 Copayment per visit	$50 Copayment per visit
Home Care Services	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance
Benefit Period Maximum Visits	90 visits, combined Network and Non-Network	

Note: Maximum does not include Home Infusion Therapy, post-delivery Home Care visits, or Private Duty Nursing rendered in the home.

Private Duty Nursing Benefit Period Maximum per Member Lifetime Maximum	$50,000 $100,000	
Hospice Services	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance
Inpatient and Outpatient Professional Services	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance
Inpatient Facility Services	$250 Copayment per admission	30% Coinsurance
Benefit Period Maximum Inpatient days for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 Inpatient days, combined Network and Non-Network	
Benefit Period Maximum days for Skilled Nursing Facility	90 days, combined Network and Non-Network	
Maternity Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance
Benefit Period Maximum for all Prosthetic devices received on an Outpatient basis. This maximum does not include the following: • surgical prosthetics; • prosthetics following a mastectomy; • hearing aids provided to a newborn for initial amplification following a newborn hearing screening.	$4,000 combined Network and Non-Network	

Benefit Period Maximum for all Durable Medical Equipment and Orthotics. This maximum does not include the following: • Physician-prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes.	$4,000 combined Network and Non-Network	

Note: If durable medical equipment or appliances are obtained through your PCP/SCP or another Network Physician's office, Urgent Care Center Services, Other Outpatient Services or Home Care Services, the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.

Outpatient Services		
Outpatient Surgery Hospital/Alternative Care Facility	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance
Other Outpatient Services	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance

Note: Physical Medicine Therapy obtained through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Physician Home Visits and Office Services		
Primary Care Physician (PCP)	$15 Copayment per visit	30% Coinsurance
The PCP Copayment/ Coinsurance also applies to the following Covered Services regardless of Outpatient setting where they are received: • Routine and Diagnostic mammograms • Diabetes self management training • Medical nutritional therapy		
Specialty Care Physician (SCP)	$15 Copayment per visit	30% Coinsurance
Allergy Injections	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	30% Coinsurance

Note: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician's office are subject to the Other Outpatient Services Copayment/Coinsurance.

The allergy injection Copayment/Coinsurance will be applied when the injections(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Immunizations for children prior to 6th birthday	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount
Surgical Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Therapy Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received

Note: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

Benefit Period Maximum Visits for:

Physical Therapy and Manipulation Therapy (not including Chiropractic Services)	45 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Occupational Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Speech Therapy	Unlimited when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Chiropractic Services	26 visits, combined Network and Non Network
Urgent Care Center Services	$35 Copayment per visit 30% Coinsurance

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

The human organ and bone marrow/stem cell transplant and transfusion services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**

- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed, subject to applicable Member cost shares.

Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)

Transplant Benefit Period	**Network Transplant Provider** Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Transplant Case Manager for specific Network Transplant Provider information) for services received at or coordinated by a Network Transplant Provider Facility.	**Non-Network Transplant Provider** Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.
Deductible	**Network Transplant Provider** Not Applicable	**Non-Network Transplant Provider** Applicable During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Facility** During the Transplant Benefit Period, No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	**Non-Network Transplant Provider Facility** During the Transplant Benefit Period, You will pay 30% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.

		If the Provider is also a Network Provider for the Plan (for services other than Covered Transplant Procedures), then you will **not** be responsible for Covered Services that exceed the Plan's Maximum Allowable Amount. If the Provider is a Non-Network Provider for the Plan, you **will** be responsible for Covered Services that exceed Our Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	**Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** You are responsible for 30% of the Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation Lodging and Meals	Covered, as approved by the Plan, up to a $10,000 benefit limit per transplant	Not Covered for Transplants received at a Non-Network Transplant Provider Facility
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved by the Plan, up to a $30,000 benefit limit per transplant	Covered, as approved by the Plan, up to a $30,000 benefit limit. You will be responsible for 30% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	No Copayment/Coinsurance up to the Plan's Maximum Allowable Amount	You are responsible for 30% of the Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Prescription Drugs		

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Retail Pharmacy (Network and Non-Network)	30 days
Mail Service	90 days

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance:

Tier 1 Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Prescription Drugs	$20 Copayment per Prescription Order
Tier 3 Prescription Drugs	$35 Copayment per Prescription Order

The Plan's Mail Service Program Prescription Drug Copayment/Coinsurance:

Tier 1 Prescription Drugs	$20 Copayment per Prescription Order
Tier 2 Prescription Drugs	$40 Copayment per Prescription Order
Tier 3 Prescription Drugs	$70 Copayment per Prescription Order

Non-Network Retail Pharmacy Prescription Drug Copayment/Coinsurance:	50% Coinsurance (minimum $45)

Note: No Copayment/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Plan's Maximum Allowable Amount when obtained from a Network Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to Prescription Drug Copayments/Coinsurance.

Note: If you request that an Equivalent Prescription Drug be dispensed by a Network Physician or other Network Provider, then you will be responsible for the payment of the following:

- the difference in price between the Tier 1 Prescription Drug and the equivalent Tier 2 or Tier 3 Prescription Drug, and
- the payment of the Tier 1 Prescription Drug Copayment and applicable Deductible and Coinsurance.

An Equivalent Prescription Drug is a Brand Name Drug that has a Tier 1 Prescription Drug equivalent.

Note: You will be responsible for only one Copayment/Coinsurance for a covered Prescription Drug if the required single dosage is unavailable and/or a combination of dosage amounts is needed to fill the Prescription Order.

4 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **To receive maximum benefits for Covered Services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, except for Emergency Care and ambulance services. Services that are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a

Non-Network Provider, except for Emergency Care and ambulance services.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. The Administrator cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Plan, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Administrator bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's clinical coverage guidelines and medical policy. The Administrator may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. The Plan's payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period Limit/Maximum, or Lifetime Maximum in this Benefit Booklet.**

Ambulance Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMTs), paramedics, or other certified medical professionals:

- from your home, scene of accident or medical Emergency to a Hospital;
- between Hospitals;
- between a Hospital and Skilled Nursing Facility; or
- from a Hospital or Skilled Nursing Facility to your home.

Other vehicles that do not meet this definition, including but not limited to ambulettes, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- when ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- when a Member is required by the Plan to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the

Member, family or Physician is not a Covered Service.

Non-Covered Services for Ambulance include, but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

Ambulance services or emergency medical response agencies that are licensed by the state of Missouri to provide the above Covered Services will be paid directly by the Plan.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services for a Recognized Mental Illness are as follows:

- Inpatient Hospital treatment for a Recognized Mental Illness to the same extent as for any other illness.
- Inpatient Facility-Based Treatment Programs for the therapeutic care and treatment of a Recognized Mental Illness when prescribed by a Licensed Mental Health Professional and rendered in a psychiatric facility licensed by the Department of Mental Health or accredited by the Joint Commission on Accreditation of Hospitals, to the same extent as any other illness.
- Outpatient treatment, including both professional services and services received through Facility-Based Treatment Programs, for mental health services for a Recognized Mental Illness rendered by a Licensed Mental Health Professional, to the same extent as any other illness.

Care for Recognized Mental Illness may be rendered by Community Mental Health Centers, Hospitals, Facility-Based Treatment Programs or other mental health service delivery entities certified by the Department of Mental Health or accredited by a nationally recognized organization or licensed by the state.

Covered Services for Substance Abuse are as follows:

- Inpatient Care through a Facility-Based Treatment Program
- Medical and Social Setting Detoxification
- Outpatient Care through a Facility-Based Treatment Program
- Physician Home Visits and Office Services

Care for Substance Abuse may be rendered by Hospitals, Facility-Based Treatment Programs, or other mental health service delivery entities certified by the Department of Mental Health or accredited by a nationally recognized organization, or licensed by the state.

Coverage for Substance Abuse will be subject to a separate lifetime Episode maximum, as specified in the Schedule of Benefits, except that such separate Episode maximum will not apply to Medical Detoxification in a life-threatening situation as determined by the treating Physician and subsequently documented within 48 hours of treatment to the reasonable satisfaction of the Plan.

Dental Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident

and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

  Benefits are provided only for the administration of general anesthesia and for both facility and professional charges occurring in connection with dental services provided for the following Members:

  1. A Member through the age of four;
  2. A Member who is severely disabled; and
  3. A Member who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental services are provided.

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

Diabetic Equipment, Education and Supplies

See the Schedule of Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances" and "Preventive Care Services".

Diagnostic Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Bone density studies.
- Cytologic and chlamydia screening (including pap test).
- Prostate specific antigen testing.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMGs are not Covered Services.
- Echocardiograms.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) and pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use the Administrators's independent laboratory Network Provider called the Reference Laboratory Network (RLN).

When Diagnostic services are performed within 3 days (72 hours) as part of pre-admission testing required for an Inpatient admission or an Outpatient surgery, no Copayment is required. Any Coinsurance will still apply.

When Diagnostic radiology is performed in a Network Physician's Office, no Copayment is required. Any Coinsurance from a Network Physician will still apply.

Emergency Care and Urgent Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. In certain circumstances, Emergency Care received from a Non-Network Provider may be approved as an Authorized Service. You must contact the Administrator for authorization prior to the claim being filed. In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an

Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, as well as supplies and Prescription Drugs charged by that facility.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify the Administrator, on behalf of the Employer, or verify that your Physician has notified the Administrator of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with the Administrator or is a BlueCard Provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determines is not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network service unless the Administrator authorizes the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. However, you must obtain Urgent Care services from a Network Provider to receive maximum benefits. Urgent Care Services received from a Non-Network Provider will be covered as a Non-Network service and you will be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

Home Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis.

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Administrator, on behalf of the Employer, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from the Administrator's Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Inpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.

- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.

- **Surgery and the administration of general anesthesia.**

- **Newborn exams.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

Maternity Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services used for pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

An elective (voluntary) abortion is one performed for reasons other than described above. Regardless of Medical Necessity, the Plan does not pay Covered Services from a Provider for elective abortion accomplished by any means.

Maternity services for a Dependent daughter are covered.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to the Administrator.

Note: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copayment.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

1. the antepartum, intrapartum, and postpartum course of the mother and infant;

2. the gestational stage, birth weight, and

clinical condition of the infant;

3. the demonstrated ability of the mother to care for the infant after discharge; and
4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

These visits will not be subject to any Home Health Care maximums.

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by the Administrator, on behalf of the Employer. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

The Plan may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by the Plan, including quantity limits, is available to you upon request. Please call the

customer service number on your Identification Card. This list is subject to change.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that the Administrator approves are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have the Plan's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the Plan's Mail Service or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

  1. Allergy serum extracts
  2. Chem strips, Glucometer, Lancets
  3. Clinitest
  4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. The Plan may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.
  5. Needles/syringes
  6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

  Covered Services include the following:

  PKU formula and low protein modified food products for the treatment of phenylketonuria or any inherited diseases of amino acids and organic acids (covered only for children through age 5.) Low protein modified food products are foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein foods do not include foods that are naturally low in protein.

  Non-Covered Services include but are not limited to:

  1. Adhesive tape, bandages, cotton tipped applicators
  2. Arch supports
  3. Doughnut cushions
  4. Hot packs, ice bags
  5. Vitamins
  6. Medijectors

  If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting

supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when the Administrator approves based on the Member's condition.

Non-covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes.

Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular

lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).
10. Hearing Aids provided to a newborn for initial amplification following a newborn hearing screening (including any necessary rescreening, audiological assessment and follow-up; see "Preventive Care"). A hearing aid is an electronic device worn or implanted for the purpose of amplifying sound and assisting the physiological process of hearing.

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

- **Orthotic devices** - Covered Services are the initial purchase, fitting, and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices may include, but are not limited to, the following:

  1. Cervical collars.
  2. Ankle foot orthosis.
  3. Corsets (back and special surgical).
  4. Splints (extremity).
  5. Trusses and supports.
  6. Slings.
  7. Wristlets.
  8. Built-up shoe.
  9. Custom made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Non-Covered Services include but are not limited to:

1. Orthopedic shoes.
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Outpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by the Plan. Outpatient Services do not include care that is related to Behavioral Health Services, except as otherwise specified. Refer to the section titled Behavioral Health Services for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

For Emergency Accident or Medical Care refer to the "**Emergency Care and Urgent Care**" section.

Physician Home Visits and Office Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include care provided by a Physician in his or her office or your home. Refer to the sections titled "Preventive Care Services", "Maternity Care", "Home Care Services", for services covered by the Plan. For Emergency Care, refer to the "Emergency Care and Urgent Care" section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Preventive Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Preventive Care services include Inpatient services, Outpatient services and Physician Home Visits and Office Services. Screenings and other services are generally covered as Preventive Care

for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.) Examinations include, but are not limited to:

    1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services include, but are not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
    2. Adult routine physical examinations.
    3. Pelvic examinations.
    4. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
    5. Annual dilated eye examination for diabetic retinopathy.

- Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Routine immunizations prior to the child's 6th birthday will not be subject to any Deductible, Coinsurance, Copayment or benefit maximums. For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians.

  These include, but are not limited to:

    1. Hepatitis A vaccine.
    2. Hepatitis B vaccine.
    3. Hemophilus influenza b vaccine (Hib).
    4. Influenza virus vaccine.
    5. Rabies vaccine.
    6. Diphtheria, Tetanus, Pertussis vaccine.
    7. Mumps virus vaccine.
    8. Measles virus vaccine.
    9. Rubella virus vaccine.
    10. Poliovirus vaccine.
    11. Varicella vaccine.

- Screening examinations:

    1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts.
    2. Routine hearing screening, including the following for newborns: hearing screenings, necessary rescreenings, audiology assessment and follow-up. Hearing Aids would also be provided to a newborn for initial amplification following the screening; see "Medical Supplies, Durable Medical Equipment, and Appliances").
    3. Routine screening mammograms for asymptomatic women.

4. Routine cytologic and chlamydia screening (including pap test).
5. Routine bone density testing for women.
6. Routine prostate specific antigen testing.
7. Routine colorectal cancer examination and related laboratory tests.
8. Testing of pregnant women and other Members for lead poisoning.

Routine patient care costs for reasonable and Medically Necessary Drugs, devices, medical treatments, procedures or other technology included as part of a Phase II, III or IV clinical trial undertaken to treat cancer. The clinical trial must be underwritten by a National Institute of Health Cooperative or an equivalent entity. Covered care includes routine patient care costs incurred for Drugs and devices related to the clinical trial. Covered items do not include: the investigational item or service itself; items and services used only for data collection, not for clinical management of the patient; or items and services customarily provided by research sponsors at no charge.

Diabetes Self Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Medical Nutritional Therapy limited to consultations for the Medically Necessary management and treatment of obesity. Any Prescription Drug or medical supply prescribed as a part of this therapy will not be covered except as otherwise stated in this Benefit Booklet.

Surgical Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by the Administrator, on behalf of the Employer.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Administrator for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under the Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for the Plan, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Sterilization

Sterilization is a Covered Service.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

They are covered if provided within the Plan's guidelines.

Therapy Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** not including Chiropractic Services, including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function. Manipulation therapy does not include chiropractic services, as identified below.
- **Chiropractic services** are available on a short-term acute basis. Chiropractic services are services provided by a licensed Chiropractor acting within the scope of his or her practice. Coverage includes the initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the Plan.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive

isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy (not including Chiropractic Care), occupational therapy, speech therapy and services of a Social Worker or Psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy (not including Chiropractic Care), Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Administrator, on behalf of the Employer, including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Covered Transplant Procedures include treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize your benefits, you are strongly encouraged you to call the Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. The Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or Exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and **ask for the transplant coordinator**. Even if the Administrator issues a prior approval for the Covered Transplant Procedure, it is recommended that you or your Provider call the Administrator's Transplant Department for precertification prior to the transplant, whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation, Meals and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator, on behalf of the Employer, when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility, lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

For meal, lodging, and ground transportation benefits, the Plan will provide a maximum benefit up to the current limits set forth in the Internal

Revenue Code.

Non-Covered Services for transportation, meals, and lodging include, but are not limited to:

- Alcohol, tobacco, or any other non-food item,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Administrator, on behalf of the Employer,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Prescription Drug Benefits

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pharmacy Benefits Manager

The pharmacy benefits available to you under the Plan are managed by the Administrator's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Administrator contracts to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service Pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and operating a Mail Service Pharmacy. The PBM, in consultation with the Administrator, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regiments; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Administrator at the Customer Service telephone number on the back of your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Plan can determine Medical Necessity. The Plan may establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a

prescription, the Network pharmacist is informed of the Prior Authorization requirement through the Pharmacy's computer system and the pharmacist is instructed to contact the Administrator or the PBM. The Administrator, or the PBM, use pre-approved criteria, developed by the Administrator's Pharmacy and Therapeutics Committee and reviewed and adopted by the Administrator. The Administrator, or the PBM, communicate the results of the decision to the pharmacist. The Administrator, or the PBM, may contact your prescribing Physician if additional information is required to determine whether Prior Authorization should be granted.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the "Complaint and Appeals Procedures" section of this Benefit Booklet.

For a list of the current Drugs requiring Prior Authorization, please contact the Administrator at the Customer Service telephone number on the back of your ID Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your Plan. Refer to the Prescription Drug benefit sections in this Benefit Booklet for information on coverage, limitations and exclusions. Please ask your Provider or Network pharmacist to check with the Administrator or with the PBM to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

Therapeutic Substitution of Drugs is a program approved by the Administrator and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. The Administrator, or the PBM, may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, contact the Administrator by calling the Customer Service telephone number on the back of your ID Card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

Step Therapy

Step therapy protocol means that a Member may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the Physician will need to submit a letter fax including the following details:

- Member name and ID number;
- Diagnosis;
- Drug name;
- Reason for appeal;
- Physician name, specialty, address and phone number.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact the Administrator to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.

- Certain Prescription Legend Drugs may be Covered Services if an over the counter equivalent exists. This list is subject to change on a semiannual basis. Please check the Administrator's website at www.anthem.com for the most current listing of medications.
- Human Growth Hormone with prior authorization by Anthem, covered the same as any other Medical and RX copay.Medical care rendered in connection with the treatment of someone who is taking growth hormones (i.e. office visits, etc.) also is a covered expense under the plan.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.

Non-Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other non-Covered Services)

- Prescription Drugs dispensed by any Mail Service program other than the Plan's Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents, unless noted as covered on the Administrator's website at www.anthem.com and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product, unless noted as covered on the website at www.anthem.com.
- Off label use, except as otherwise prohibited by law or as approved by the Administrator or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services
- Any Drug that is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities that exceed the limits established by the Plan, or which exceed any age limits established by the Plan.
- Any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.

- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. **Please contact the Administrator for additional information on these Drugs.**

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and Coinsurance/Copayment amount may also apply.

Generic Drug Encouragement

The Plan may, from time to time, offer incentives to encourage the use of Generic Drugs. This may involve waiving a Copayment/Coinsurance for certain Generic Drugs for a period of time, or other incentives.

Days Supply

The number of days supply of a Drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days supply allowed for under the Plan, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

Tiers

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug has been classified by the Plan as a first, second or third, "tier" Drug. The determination of tiers is made by the Administrator, on behalf of the Employer, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 generally includes Generic Prescription Drugs.
- Tier 2 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs.
- Tier 3 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other Drugs in lower tiers.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, a Non-Network Pharmacy, or the Plan's Mail Service Program. It is also based upon which Tier the Administrator has classified the Prescription Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The Administrator, on behalf of the Employer, retains the right at its discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network Pharmacy or through the Plan's Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy – Present your written Prescription Order from your Physician and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to the Administrator with a written request for refund.

Non-Network Pharmacy – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to the Administrator for reimbursement consideration. These forms are available from the Administrator or from the Employer. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to the Administrator. The itemized receipt must show:

- name and address of the Non-Network Pharmacy;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the Drug;
- cost of the prescription;
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by the Plan or the PBM's normal or average contracted rate with Network pharmacies on or near the date of service.

The Plan's Mail Service – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill.

5 NON COVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for procedures, equipment, services, supplies or charges:

1. that the Administrator, on behalf of the Employer, determines are not Medically Necessary or does not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines, except reasonable and Medically Necessary Drugs, devices, medical treatments, procedures or other technology included as part of a Phase III or IV clinical trial undertaken to treat cancer. The clinical trial must be underwritten by a National Institute of Health Cooperative or an equivalent entity. Covered care includes routine patient care costs incurred for Drugs and devices related to the clinical trial. Covered items do not include: the investigational item or service itself; items and services used only for data collection, not for clinical management of the patient; or items and services customarily provided by research sponsors at no charge.

2. received from an individual or entity that is not a Provider, as defined in this Benefit Booklet, or recognized by the Plan.

3. that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of the Employer, except reasonable and Medically Necessary Drugs, devices, medical treatments, procedures or other technology included as part of a Phase III or IV clinical trial undertaken to treat cancer. The clinical trial must be underwritten by a National Institute of Health Cooperative or an equivalent entity. Covered care includes routine patient care costs incurred for Drugs and devices related to the clinical trial. Covered items do not include: the investigational item or service itself; items and services used only for data collection, not for clinical management of the patient; or items and services customarily provided by research sponsors at no charge. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if the Administrator, on behalf of the Employer, deems it to be Experimental/Investigational.

4. for any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

5. to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6. for any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, the Administrator, on behalf of the Employer, will refund any Fees paid from the date the Member enters the military.

7. for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

8. for court ordered testing or care unless the service is Medically Necessary.

9. for which you have no legal obligation to pay in the absence of this or like coverage.

10. for any Pre-Existing Condition for the time period specified in the Schedule of Benefits, subject to the Portability provision of this Benefit Booklet. This Exclusion is not applicable to newborns, adopted children or children placed for adoption who are enrolled under the Plan within 31 days of the date of birth or placement for adoption.

11. for the following:

    - Physician or Other Practitioners' Charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member;
    - surcharges for furnishing and/or receiving medical records and reports.
    - charges for doing research with Providers not directly responsible for Your care.
    - charges that are not documented in Provider records.
    - charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

12. received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

13. prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

14. for completion of claim forms or charges for medical records or reports, unless otherwise required by law.

15. for missed or canceled appointments.

16. for mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Administrator, on behalf of the Employer, or specifically stated as a Covered Service.

17. for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

18. in excess of the Plan's Maximum Allowable Amounts.

19. incurred prior to your Effective Date.

20. incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.

21. for reconstructive services, except as specifically stated in the "Covered Services" section of this Benefit Booklet, or as required by law.

22. provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by the Administrator, on behalf of the

Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under the Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

23. for maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

24. for the following:

    - Custodial, convalescent care or rest cures; domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    - care provided or billed by residential treatment centers or facilities, unless those centers are required to be covered by state law. This includes, but is not limited to, individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
    - services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
    - wilderness camps

25. for routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:

    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

26. for surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

27. for dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.

28. for treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
29. for Dental implants.
30. for Dental braces.
31. for Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as explained in the “Covered Services” section of this Benefit Booklet. The only exceptions to this are for any of the following:
    - transplant preparation.
    - initiation of immunosuppressives.
    - direct treatment of acute traumatic injury, cancer or cleft palate.
32. for treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
33. for weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in the "Covered Services" section. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
34. for bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by the Administrator, on behalf of the Employer, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under the Plan or any previous plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under the Plan. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.
35. for marital counseling.
36. for prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
37. for vision orthoptic training.
38. for hearing aids or examinations for prescribing or fitting them, except as specified in the “Covered Services” section of this Benefit Booklet.
39. for services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
40. for reversal of sterilization.

41. for testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.

42. for personal hygiene, environmental control, or convenience items including but not limited to:

    - air conditioners, humidifiers, air purifiers;
    - physical fitness equipment such as a treadmill or exercise cycles;
    - special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - charges from a health spa or similar facility;
    - personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - charges for non-medical self-care except as otherwise stated;
    - purchase or rental of supplies for common household use, such as water purifiers;
    - hypoallergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - infant helmets to treat positional plagiocephaly; safety helmets for Members with neuromuscular diseases; or sports helmets.

43. for telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Administrator, on behalf of the Employer.

44. for care received in an emergency room that is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to, suture removal in an emergency room.

45. for eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.

46. for self-help training and other forms of non-medical self care, except as specified in the "Covered Services" section of this Benefit Booklet.

47. for examinations relating to research screenings.

48. for stand-by charges of a Physician.

49. for physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

50. related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

51. for Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.

52. for Manipulation Therapy services rendered in the home as part of Home Care Services.

53. for any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may waive this exclusion

in whole or in part for a specific New FDA Approved Drug Product or Technology.

54. for services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

55. for elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

56. for nutritional and dietary supplements, except as provided in the "Covered Services" section of this Benefit Booklet. This exclusion includes, but is not limited to, those supplements that by law do not require either the written prescription of a Physician or dispensing by a licensed pharmacist. It also includes vitamins and food replacements, such as infant formulas and enteral formulas.

57. for (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology (study of the iris), auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy and neurofeedback.

58. for hiring, or the services of, a surrogate mother.

59. for surgical treatment of gynecomastia.

60. for treatment of hyperhidrosis (excessive sweating).

61. for any service for which you are responsible under the terms of this Benefit Booklet to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

62. for Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Administrator, on behalf of the Employer, through Prior Authorization.

63. for services, supplies and equipment for the following:

    - gastric electrical stimulation.
    - hippotherapy.
    - intestinal rehabilitation therapy.
    - prolotherapy.
    - recreational therapy.
    - sensory integration therapy (SIT).

64. for extracorporeal shock wave treatment for plantar fasciitis and other musculoskeletal conditions.

65. for complications directly related to a service or treatment that is a non-Covered Service under the Plan because it was determined by the Administrator, on behalf of the Employer, to be Experimental/Investigational or not Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

66. for Drugs, devices, products, or supplies with over the counter equivalents, unless noted as covered on the Administrator's website at www.anthem.com and any Drugs, devices,

products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply, unless noted as covered on the Administrator's website at www.anthem.com.

67. for sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68. for treatment of telangiectatic dermal veins (spider veins) by any method.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Administrator, on behalf of the Employer, determines to be Experimental/Investigative is not covered under the Plan.

The Administrator, on behalf of the Employer, will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Administrator, on behalf of the Employer, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Administrator, on behalf of the Employer. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Administrator, on behalf of the Employer, to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Administrator, on behalf of the Employer, will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

6 ELIGIBILITY AND ENROLLMENT

You have coverage provided under the Plan because of your employment with/membership with/retirement from the Employer. You must satisfy certain requirements to participate in the Employer's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Employer or state and/or federal law and approved by the Administrator, on behalf of the Employer.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

The following eligibility rules apply unless you are notified by the Employer.

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be either: an employee, member, or retiree of the Employer, and:
- Be entitled to participate in the benefit plan arranged by the Employer;
- Have satisfied any probationary or waiting period established by the Employer and be Actively At Work;
- Meet the eligibility criteria stated in the Administrative Services Agreement.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by

the Subscriber, meet all Dependent eligibility criteria established by the Group and be:

- The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives.
- The Subscriber's spouse or Domestic Partner as recognized under the laws of the state where the Subscriber lives. If the Subscriber's legal spouse or Domestic Partner is **eligible to be** covered as a subscriber under **the spouse's or the Domestic Partner's employer's** employer-sponsored group health plan, the spouse or Domestic Partner is not eligible for coverage under this Plan, except as described under Special Enrollment.
- The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex who has signed the Domestic Partner Affidavit certifying that: he or she is the Subscriber's or the Eligible Person's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; neither the Subscriber nor the Eligible Person is related by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber or Eligible Person.

  For purposes of this Certificate, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's unmarried child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

  Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

  To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.
- The Subscriber's or the Subscriber's spouse's unmarried children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- Unmarried children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible, unmarried children will continue to be covered until the age limit listed in the Schedule of Benefits.

Eligibility will be continued past the age limit only for those already enrolled unmarried Dependents who cannot work to support themselves due to physical or mental handicap. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. Subsequent proof of the child's disability and dependency must be provided upon Our request. Proof may be required at reasonable intervals during the first two years after the child reaches the Dependent age limit, and no more frequently than once each year thereafter. You must notify Us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, We may require that the Subscriber complete a

"Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

Enrollment

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Administrative Services Agreement or the Plan's underwriting rules for initial application for enrollment. If the Administrator does not receive the initial application by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

Continuous Coverage

If you were covered by the Employer's prior carrier or plan immediately prior to the Employer's enrollment with the Administrator, with no break in coverage, then you will receive credit for any accrued Deductible and, if applicable and approved by the Administrator on behalf of the Employer, Out-of-Pocket amounts under that other plan. This does not apply to persons who were not covered by the prior carrier or plan on the day before the Employer's coverage with the Administrator began, or to persons who join the Employer later.

If your Employer moves from one of the Administrator's plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then you may receive credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by the Administrator, on behalf of the Employer. Any any maximums, including the Lifetime Maximum, when applicable, will be carried over and charged against the maximums or Lifetime Maximum under the Plan.

If your Employer offers more than one of the Administrator's products, and you change from one of those products to another with no break in coverage, you will receive credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums, including the Lifetime Maximum will be carried over and charged against the maximums, including the Lifetime Maximum.

If your Employer offers coverage through other products or carriers in addition to the Administrator's coverage, and you change products or carriers to enroll in this product with no break in coverage, you will receive credit for any accrued Deductible, Out-of-Pocket, any maximums, including the Lifetime Maximum amounts.

This Section Does Not Apply To You If:

- you change from one of the Administrator's individual policies to one of the Administrator's group plans;
- you change employers and both have the Administrator's coverage; or
- you are a new Member of the Employer who joins the Employer after the Employer's initial enrollment with the Administrator. Such new Members will receive credit from their prior carrier as described in the "Portability" section.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days only if the Subscriber submits through the Employer, or the Plan, a request to add the child under the Subscriber's Plan. The request must be submitted within 31 days after the birth of the child or within 10 days after the Administrator provides the form, whichever is later. Failure to notify the Plan during this period will result in no coverage for the newborn beyond the first 31 days, except as permitted for a Late Enrollee.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If the Administrator does not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under the Plan, the Plan will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of the Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under the Plan will be paid, at the Plan's discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Employer will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Administrator directly.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If the Administrator receives an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee. Application forms are available from the Plan.

Late Enrollees

You are considered a Late Enrollee if you are an Eligible Person or Dependent who did not request enrollment for coverage:

- During the initial enrollment period; or
- During a Special Enrollment period; or
- As a newly eligible Dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of the date you were first entitled to enroll.

You may only apply for coverage at any time during the year as a Late Enrollee.

However, you will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

Open Enrollment Period

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Employer's next annual enrollment and may be subject to a Pre-Existing Condition waiting period, not to exceed the Exclusion Period stated in the Schedule of Benefits.

Open Enrollment means a period of time (at least 31 days prior the Employer's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

Portability

Any Pre-Existing Condition waiting period will be reduced by the aggregate of the periods of prior creditable coverage applicable to you as of your Enrollment Date. Creditable coverage is prior coverage you had from: a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under the Plan. You have the opportunity to prove that you have prior creditable coverage and The Administrator and/or the Employer will assist you in obtaining that information if required.

Notice of Changes

The Subscriber is responsible for notifying the Employer of any changes that will affect his or her eligibility or that of Dependents for services or benefits under the Plan. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify the Administrator, on behalf of the Employer, of persons no longer eligible for services will not obligate the Plan to pay for such services. Acceptance of payments from the Employer for persons no longer eligible for services will not obligate the Plan to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Employer must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the last day of the billing period in which the Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability or age.

Effective Date of Coverage

For information on your specific Effective Date of Coverage under the Plan, please see your human resources or benefits department. You can also contact the Administrator by calling the number located on the back of your Identification (ID) Card.

Statements and Forms

Subscribers (or applicants for membership) must complete and submit applications, medical review questionnaires or other forms or statements the Plan may reasonably request.

Applicants for membership understand that all rights to benefits under the Plan are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination and Continuation" section. The Administrator, on behalf of the Employer, will not terminate the Plan on the basis of application misstatements after two years have passed since the Enrollment Date.

Delivery of Documents

The Administrator, on behalf of the Employer, will provide an Identification Card for each Member and a Benefit Booklet for each Subscriber.

7 CHANGES IN COVERAGE: TERMINATION AND CONTINUATION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Employer's specific requirements:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which the Administrator received your notice of termination.
- Subject to any applicable continuation requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage generally will terminate on the last day of the billing period. You must notify the Employer immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you engage in fraudulent conduct or furnish the Plan fraudulent or misleading material information relating to claims or application for coverage, then the Employer may terminate your coverage immediately, retroactive to the date of fraud or material misrepresentation. You are responsible to pay the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services. On the date your coverage is terminated, the Employer will also terminate your Dependent's coverage.
- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by the Administrator that the person no longer meets the definition of Dependent, unless the termination is due to fraud or material misrepresentation as explained above.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's health benefit plan which is offered by, through, or in connection with the Employer as an option instead of the Plan, then coverage for you and your Dependents will generally terminate at the end of the billing period for which Fees have been paid.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Fees or contributions in accordance with the terms of the Plan, the Employer may terminate your coverage and may also

terminate the coverage of all your Dependents, generally effective immediately upon their written notice to you.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

Removal of Members

Upon written request through the Employer, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another group health plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certifications may be requested within 24 months of losing coverage. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.

Continuation

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under an Employer that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health plan. It can also become available to other Members of your family, who are covered under the Employer's health plan, when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Employer's health plan, you should contact the Employer.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, the Employer must offer COBRA continuation coverage to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer's health plan is lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for Fee payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Employer's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Employer's health plan as a "Dependent child."

If Your Employer Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Employer's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Employer's health plan.

When is COBRA Coverage Available?

The Employer will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then the employer will notify the COBRA Administrator (e.g., Human Resources, external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Employer receives notice that a qualifying event has occurred, they will offer COBRA continuation coverage to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits

less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Employer's health plan is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Employer. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Employer's health plan had the first qualifying event not occurred.

Trade Act of 1974

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their group health plan coverage ended.

If you, the Subscriber, qualify for assistance under the Trade Act of 1974, you should contact the Employer for additional information. You must contact the Employer promptly after qualifying for assistance under the Trade Act of 1974 or you will lose these special COBRA rights.

Fees and the End of COBRA Coverage

Fees will be no more than 102% of the Employer rate (unless your coverage continues beyond 18 months because of a disability. In that case, Fees in the 19th through 29th months may be 150% of the Employer rate).

Continued coverage ends earlier if the plan ends or if the person covered:

- fails to pay Fees timely;
- after the date of election, first becomes covered under another group health plan which contains no pre-existing condition limitations or exclusions;

- after the date of election, first becomes covered under another group health plan which contains a pre-existing condition limitation or exclusion which you have satisfied pursuant to the federal Health Insurance Portability and Accountability Act of 1996, as first enacted or later amended; or
- after the date of election, first becomes entitled to Medicare benefits.

If You Have Questions

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. Employers must provide a cumulative total of five years, and in certain instances more than five years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by the Act, the law requires Employers to continue to provide coverage under the Plan for its members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your Employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and Employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During Military Leave

Continued coverage under USERRA will terminate on the earlier of the following events:

1. The date you fail to return to Active Work with the Employer following completion of your military leave. Employees must return to Active Work within:
   - the first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
   - 14 days after completing military service for leaves of 31 to 180 days,
   - 90 days after completing military service, for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan if you return within:

- the first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
- 14 days of completing your military service, for leaves of 31 to 180 days; or
- 90 days of completing your military service, for leaves of more than 180 days.

If, due to an Illness or Injury caused or aggravated by your military service, you cannot return to Active Work within the times stated above, you may take up to:

- two years; or
- as soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such Illness or Injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under the Plan. Any Probationary Periods will apply only to the extent that they applied before and the Pre-existing Condition Limitation Period will be credited as if you had been continually covered under the Plan from Your original Effective Date.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, the Plan will not provide coverage for any Illness or Injury caused or aggravated by your military service, as indicated in the "Non-Covered Services / Exclusions" section.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Employer must provide the Administrator with evidence satisfactory to the Employer of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

8 HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Provider. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, ambulance services, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider, or the Administrator to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets the Plan's

enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with the Plan.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be paid at the Network level and you will not be financially responsible for any Covered Services that the Administrator, on behalf of the Employer, determines is not Medically Necessary. However, regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. The Administrator, on behalf of the Employer, determines the Medical Necessity of the service.

The Administrator, on behalf of the Employer, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Complaint and Appeals Procedures" section of this Benefit Booklet.

- **Network Providers** - include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with the Administrator to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

For services rendered by Network Providers:

1. You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Deductibles, Coinsurance and/or Copayments. You may be billed by your Network Provider(s) for any non-Covered Services you receive or when you have not acted in accordance with the Plan.

2. Health Care Management is the responsibility of the Network Provider.

   If there is no Network Provider who is qualified to perform the treatment you require, contact the Administrator prior to receiving the service or treatment and the Administrator, on behalf of the Employer, may approve a Non-Network Provider for that service as an Authorized Service.

Non-Network Services

Services that are not obtained from a PCP, SCP, or another Network Provider or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care and ambulance services.

For services rendered by a Non-Network Provider, you are responsible for:

- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

Note: Except as otherwise noted in this Benefit Booklet, all services covered by a Network Provider are also covered by a Non-Network Provider.

Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under the Plan. At times, a Network Provider may recommend that you obtain services that are not covered under the Plan. If a Network Provider clearly informs you that the Plan may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. The Plan and the Administrator's Network Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of the Plan. The Plan will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Fees under the Plan has the right to services or benefits under the Plan. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Benefit Booklet, he/she is responsible for the actual cost of the services or benefits.

9 CLAIMS PAYMENT

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

How Benefits Are Paid

Maximum Allowable Amount

The amount that the Administrator, on behalf of the Employer, or the Administrator's Subcontractor, determines is the maximum payable for Covered Services you receive. Generally, to determine the Maximum Allowable Amount for a Covered Service, the Administrator

or the Administrator's Subcontractor use, in addition to other information, internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement for this product, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Administrator for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

For a Non-Network Provider that is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, the Administrator, on behalf of the Employer, shall have discretionary authority to establish, as the Administrator deems appropriate, the Maximum Allowable Amount. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount determined by the Administrator, after consideration of one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that the Administrator may have made, or other factors the Administrator, on behalf of the Employer, deems appropriate. It is your obligation to pay any Deductibles, Coinsurance and Copayments and any amounts that exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its participation agreement with the Administrator, on behalf of the Employer.

Member Share of Cost

What you pay often depends on the type of service you receive and if you use a Network or Non-Network Provider. Refer to the "Schedule of Benefits" section of this Benefit Booklet to see what amount you are required to pay for each Covered Service.

The Plan shares the cost of your medical expenses with you up to a pre-determined amount, or the Maximum Allowable Amount. The Plan will not pay any portion of any charge that exceeds this amount.

Services may be subject to a Deductible, Coinsurance and/or Copayment, as outlined in the Schedule of Benefits. Deductibles will be based on the Maximum Allowable Amount. Coinsurance and Copayments are your share of the cost for Covered Services, and generally Copayments must be paid at the time you receive the Covered Services. The Plan pays the share of the balance up to the Maximum Allowable Amount.

Network Providers will seek payment from the Plan for Covered Services for the Maximum Allowable Amount, and will accept this amount as full payment.

If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual amount billed and the Maximum Allowable Amount, plus any Deductible, Coinsurance, Copayments and charges for non-Covered Services.

However, these guidelines change when you receive Covered Services in a Network Provider facility, but from a Non-Network Provider. If you receive Covered Services in a Network Provider facility from a Non Network Provider, such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this product. You may be liable for the difference between the billed charge and the

Plan's Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Plan will not pay any portion of any charge that exceeds the Maximum Allowable Amount.

Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, the Plan will not honor a request to withhold payment of the claims submitted.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowable Amount. **If services are performed by Non-Network Providers**, then you are responsible for any amounts charged in excess of the Plan's Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Administrator for more information.

Assignment

The Employer cannot legally transfer coverage under the Plan, without obtaining written permission from the Plan. Members cannot legally transfer the coverage. Benefits available under the Plan are not assignable by any Member without obtaining written permission from the Plan, unless in a way described in this Benefit Booklet.

If Prescription Drugs are provided by a licensed pharmacist, the Administrator, on behalf of the Employer, will recognize a valid assignment by you to the pharmacist of your right to receive payment for the Prescription Drugs subject to the following conditions:

The claim must provide all of the information specified above, and

the Plan's payments must not have been made to You prior to the Administrator's receipt of the assignment.

Notice of Claim

Written notice of a claim must be submitted to the Administrator within 20 days of when the Covered Services were provided. All claims must be submitted to the Administrator within 15 months of when the Covered Services were provided, except in the absence of legal capacity.

The Administrator, on behalf of the Employer, will process the claim within 30 days of its receipt, unless information necessary to process the claim is not available. In that case, the Administrator, on behalf of the Employer, will process the claim within an additional 15 days.

Claims not processed by the 45th day of receipt require interest of 12% of the reimbursable amount per year, compounded daily, to be paid to the Provider or individual who filed the claim.

If the Administrator, on behalf of the Employer, does not respond within 40 days of receipt to a claim filed by a Provider, and that Provider sends notice to the Administrator of its failure to process the claim, the Administrator, on behalf of the Employer, must pay that Provider $20 per day, starting on the 45th day of receipt, until the claim is processed.

All Benefits payable under the Plan will be paid no more than 30 days after receipt of due proof of loss.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Administrator, or contact customer service and ask for a claim form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claim form within that time, you will be deemed to have complied with the notice of claim requirements upon submitting, within the time period specified in earlier in this section, written notice of services rendered. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- Your signature and the Provider's signature.

The Administrator, on behalf of the Employer, will respond to a filed claim within 10 days of its receipt by:

- sending an acknowledgement of the date the Administrator received your claim; or
- sending notice of the status of the claim that includes a request for additional information.

These provisions do not apply if the Administrator, on behalf of the Employer, pays the claim within 10 days after it was received.

Claims submitted by a public (government operated) Hospital or clinic will be paid by the Administrator directly, as long as you have not already received benefit under that claim. The Administrator, on behalf of the Employer, will pay all claims within 30 days after receiving proof of loss. If you are dissatisfied with the Administrator's denial or amount of payment, You may request that the Administrator, on behalf of the Employer, review the claim a second time, and you may submit any additional relevant information.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payer) will be responsible for any charge for services.

You agree (on behalf of yourself and as authorized representative of your enrolled Dependents) to furnish all information required by the Administrator, its affiliates, agents or designees, and that any Provider, insurance or reinsurance company, health services corporation, health maintenance organization, medical information bureau, Medicare fiscal agent, consumer reporting agency, employer or third party administrator, is authorized and directed to release any and all information relating to history, diagnosis, prognosis, treatment and Covered Services relating to any condition (including but not limited to alcohol/Substance Abuse and HIV) to the Administrator, its affiliates, agents or designees, who are also authorized to receive and release such information in connection with: investigating, evaluating and/or processing claims; utilization, credentialing, quality or medical management programs; managing the provision of services; insurance; and carrying out any other lawful purpose relating to coverage.

This authorization remains valid until expressly revoked by notifying the Administrator, its affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may

be required or authorized by law). Refusal to consent to the release of such information to the Administrator, its affiliates, agents or designees will permit the Plan to deny claims for benefits.

Overpayment of Claims

If the Administrator, on behalf of the Employer, makes any payment to a Provider, to You, or to any other organization that is wholly or partially incorrect under the terms of the Plan, the Administrator, on behalf of the Employer, will seek reimbursement from You, the Provider or other organization to which payment was made. The Administrator, on behalf of the Employer, will not request a refund or offset against a claim more than 12 months after paying the claim, except in cases of fraud or misrepresentation by the Provider. This will apply regardless of the reason for the overpayment. This provision will survive the termination of the Plan.

Explanation of Benefits (EOB)

After you receive medical care, you will generally receive an explanation of benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill but a statement from the Plan to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

BlueCard Program

Under the BlueCard Program, when you obtain health care services outside the geographic area the Administrator serves, the amount you pay for Covered Services is usually calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Administrator.

Often this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Administrator, on behalf of the Employer, would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the

Customer Service number on your ID Card or go to www.anthem.com for more information about such arrangements.

10 HEALTH CARE MANAGEMENT

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements. Other types of reviews may be conducted prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or to determine which services require Precertification, call the Precertification telephone number on the back of your Identification Card or refer to the Administrator's website, www.anthem.com.

Members are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information used to determine the outcome of the Member's Precertification request.

Your right to benefits for Covered Services provided under the Plan is subject to certain policies, guidelines and limitations, including, but not limited to, the Administrator's clinical coverage guidelines, medical policy and Health Care Management features listed in this section.

A description of each Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

Clinical Coverage Guidelines

The Administrator's clinical coverage guidelines such as medical policy, preventive care clinical coverage guidelines, Precertification review guidelines, Concurrent review guidelines, and Retrospective review guidelines, reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of clinical coverage guidelines is to assist in the interpretation of Medical Necessity. However, the Benefit Booklet and the Administrative Services Agreement take precedence over the clinical coverage guidelines. Medical technology and standards of care are constantly changing and the Administrator, on behalf of the Employer, reserves the right to review and update the clinical coverage guidelines periodically.

Precertification

Precertification is a Health Care Management feature that requires that an approval be obtained from the Administrator before incurring expenses for certain Covered Services. The Plan's procedures and timeframes for making decisions for Precertification requests differ depending on when the request is received and the type of service that is the subject of the Precertification request.

Urgent Review means a review for medical care or treatment that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment, or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. The Plan, applying the prudent layperson standard, may determine that an Urgent Review should be conducted. Depending on the circumstances,

Concurrent reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. The care will be covered according to your benefits for the number of days approved unless the Plan's Concurrent review determines that the number of days should be revised. If a request is denied, the Provider may request a reconsideration. The Plan's Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Member's health requires an earlier decision.

Most Providers know which services require Precertification and will obtain any required Precertification. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. Generally, the ordering Provider, facility or attending Physician will call to request a Precertification review ("requesting Provider"). The Administrator, on behalf of the Employer, will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on the Plan's process for designating an authorized representative, call the Precertification telephone number on the back of your Identification Card.

You are responsible for obtaining Precertification for certain services you obtain:

- from a Non-Network Provider; or
- from a Network Provider through the local Blue Cross and Blue Shield Plan if you are traveling or you live outside of the Service Area.

When it is your responsibility to obtain Precertification, you should either:

- verify that the Non-Network or BlueCard Provider obtains the required Precertification; or
- obtain the required Precertification yourself.

If the required Precertification is not obtained, a Retrospective review will be done to determine if your care was Medically Necessary. If the Administrator, on behalf of the Employer, determines the services you receive are not Medically Necessary under your Plan and you received your care from a BlueCard Provider or a Provider that does not have a participation agreement with the Administrator, you will be financially responsible for the services.]

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify the Administrator or verify that your Physician has notified the Administrator of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate the number of days considered Medically Necessary. By calling the Administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a participation agreement with the Administrator or is a BlueCard Provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determines is not Medically Necessary.

For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Precertification Procedures

Prospective review means a review of a request for coverage of services that is conducted prior to a Member's Hospital admission, procedure or

course of treatment. For Prospective reviews, a decision will be made and telephone notice of the decision will be provided to the requesting Provider, as soon as possible, taking into account the medical circumstances, but not later than two business days (no longer than 72 hours) from the time the Administrator receives all the necessary information to make a decision. If the Administrator, on behalf of the Employer, approves the admission or course of treatment, the Administrator will provide written or electronic confirmation of the decision to the Member and the Provider within two business days of making the decision. If the Administrator does not approve the admission or course of treatment, the Administrator will provide written or electronic confirmation of the decision to the Member and the Provider within one business day of making the Adverse Determination. An Adverse Determination is a determination by the Administrator or the Administrator's designee utilization review organization that an admission, availability of care, continued stay or other care has been reviewed and, based upon the information provided, does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated.

If a Member receives Emergency Care that requires immediate post evaluation or post stabilization services, the Administrator, on behalf of the Employer, will provide a decision within 30 minutes of receiving a request. If the decision is not made within that time, the services will be deemed approved.

If additional information is needed to certify benefits for services, the Administrator will notify the requesting Provider and you or your authorized representative within 15 days of the Administrator's receipt of the specific information necessary to complete the review. For Urgent Reviews, the Administrator will notify the requesting Provider by telephone of the specific information necessary to complete the review within 24 hours after the Administrator's receipt of the request.

The requested information must be provided to the Administrator within 45 calendar days from receipt of the Administrator's request. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. For Urgent Reviews, the requested information must be provided within 48 hours after the Administrator's request for specific information. A decision will be made as soon as possible, but not later than two business days (two calendar days for Urgent Reviews) after the Administrator's receipt of the requested information. The Administrator, on behalf of the Employer, will notify the requesting Provider within 24 hours after making its decision.

If a response to the Administrator's request for specific information is not received or is not complete by the specified date, a decision will be made based upon the information in the Administrator's possession no later than two business days after the expiration of the period to submit the requested information. Telephone notice will be provided to the requesting Provider within 24 hours after the decision is made. Written notice of the Prospective review decision will be provided to you and your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

Concurrent Review

Concurrent review means a review of a request for coverage of services that is conducted during a Member's Inpatient Hospital stay or course of treatment. As a result of Concurrent review, additional benefits may be approved for care that exceeds the benefit(s) originally authorized by the Administrator's Health Care Management staff.

If a request for Concurrent review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by the Administrator. If the request is not received within 24 hours prior to the end of the approved care, the decision will be

made within one business day, from the time all necessary information is received by the Administrator. The Administrator will notify the requesting Provider by telephone within 24 hours after making the decision.

For Concurrent reviews that do not qualify for Urgent Review, the decision will be made within one business day from the time all necessary information is received. The Administrator will notify the requesting Provider by telephone within 24 hours after making the decision.

If additional information is needed to certify coverage for services for a Concurrent review that does not qualify for Urgent review, the Administrator will notify the requesting Provider by telephone and will send written notice to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review within one business day after receipt of the request. You or your authorized representative and the requesting Provider have 45 calendar days from receipt of the Administrator's request to provide the information. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made within one business day from the time the requested information is received. The Administrator will notify the requesting Provider by telephone within 24 hours after making the decision.

If a response to the Administrator's request for specific information is not received or is not complete by the specified date, a decision will be made based upon the information in the Administrator's possession no later than one business day after the expiration of the period to submit the requested information. Telephone notice will be provided to the requesting Provider within 24 hours after the decision has been made.

Written notice of Concurrent review decisions will be sent to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered. If the Administrator approves the request, the written notice will include the number of extended days that will be covered or the next review date, the new total number of days approved and the date of admission or start of services.

The Administrator will not reduce or terminate **a previously approved** on-going course of treatment until you or your authorized representative receive telephone notice of the Administrator's decision and have an opportunity to appeal the decision and receive notice of the appeal decision.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after health care services have been provided to a Member. If Precertification is required but not obtained prior to the service being rendered, the Administrator will conduct a Retrospective review. Further, if a service is subject to a clinical guideline, but Precertification is not required for that service, the Administrator may conduct a Retrospective review.

Retrospective review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For Retrospective review, a decision will be made within 30 calendar days from the time the claim is received by the Administrator. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within 10 business days of the date the decision is rendered.

If additional information is needed to certify benefits for services, the Administrator will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim.

For Retrospective reviews, you or your authorized representative and the requesting Provider have 45 calendar days from receipt of the Administrator's request to be provided the information.

Note: If the 45th day falls on a weekend or

holiday, the time frame for submission is extended to the next business day. A decision will be made within 15 calendar days from the time the requested information is received by the Administrator. If a response to the Administrator's request for specific information is not received or is not complete by the specified date, a decision will be made based upon the information in the Administrator's possession not later than 15 calendar days after expiration of the period to submit the requested information. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within the 15 days.

Case Management (Includes Discharge Planning)

Case management is a health care management feature designed to promote the most appropriate and cost effective care setting. This feature allows the Plan to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Administrator's health care management staff. In managing your care, the Administrator, on behalf of the Employer, has the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

11 COMPLAINT AND APPEALS PROCEDURES

If you have a complaint, please call 1-800-392-1104. A Client Services representative will review your records and investigate your complaint.

If you are not satisfied with the review and the Plan's response, You, your health care provider or your authorized representative acting upon your behalf, may file an appeal or a grievance. You also may file an appeal or grievance without first requesting a review. An "**appeal**" is a **written complaint** that involves any nonpayment of benefits (an **adverse benefit determination**). A "**grievance**" is a **written complaint** about the **availability, delivery** or **quality of health care services.** The Plan will not charge you anything to file an appeal or a complaint.

How To File a Expedited Appeal Review

If your complaint concerns a decision or action by the Administrator that could significantly increase the risk to your life, health, or ability to regain maximum function, the appeal may be made by phone, or fax instead of going through the mail. Please call 1-800-992-5498, or fax your request to 314-923-8542. This is an **expedited** appeal. The Administrator, on behalf of the Employer, will notify the person filing the appeal within 24 hours of all information needed to evaluate the appeal.

Then, the Administrator, on behalf of the Employer, will make a decision within 24 hours after the Administrator receives the information and notifies you orally of the determination within 72 hours after receipt of the expedited review request. The Administrator, on behalf of the Employer, will send written confirmation to you within three working days.

How To File a First Level Appeal or Grievance for Review

A standard appeal or grievance should be submitted to the Administrator in writing and sent to the address listed below:

Anthem Grievance Unit

P.O. Box 14882

St. Louis, MO 63178-4882

If you send the Administrator a written complaint, please include with your letter any records or other information you believe supports your appeal or grievance. The Administrator will carefully consider your complaint. The Plan will not charge you anything to file a grievance, and filing a grievance will not affect your benefits.

The Administrator, on behalf of the Employer, will acknowledge receipt of the appeal or grievance within 10 working days, unless it is resolved within that period of time.

Then, the Administrator, on behalf of the Employer, will conduct a complete investigation of the appeal or grievance within 20 working days after receipt of it, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of the appeal or grievance, you will be notified in writing on or before the 20th working day, and the investigation will be completed within 30 additional days. The notice will include specific reasons why additional time is needed for the investigation.

A person or committee who was not involved in the initial decision and does not report to, or is not subordinate to, the person involved in the initial decision, will review your complaint. If the decision you are asking the Administrator to review was based on a medical judgment, the review will include consultation with a health care professional who has training and experience in the appropriate medical field and who was not involved in the initial decision. The person or committee who reviews your appeal will not be bound by, or be expected to defer to, the initial decision.

Within five working days after the investigation is completed, the representative not involved in the circumstances giving rise to your appeal or grievance or its investigation will decide upon the appropriate resolution and notify you in writing of the Administrator's decision and your right to file an appeal or grievance for a second review. The notice will explain the resolution of the appeal or grievance and the right to appeal in terms that are clear and specific. You, or the person who filed the appeal or grievance upon your behalf, will be notified of the resolution within 15 working days.

If the Administrator, on behalf of the Employer, denies your appeal and you are a member of a group plan governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring a civil action in federal court under ERISA Section 502(a)(1)(B). In any case, if the Administrator, on behalf of the Employer, denies your appeal, you may voluntarily request a second appeal by writing to the address above. If you are a member of a group governed by ERISA, you are not required to file this appeal before bringing a civil action. If you do file a voluntary second appeal, the Administrator, on behalf of the Employer, agrees that any applicable statute of limitation will be temporarily suspended while the second appeal is pending.

How to File a Second Level Appeal or Grievance for Review

If you remain dissatisfied with the response to the first level review, you may submit any additional information, including written comments, records or documents that you want the Administrator to consider along with your letter of appeal, addressed to the Administrator at the address below.

Anthem Grievance Unit

P.O. Box 14882

St. Louis, MO 63178-4882

The appeal or grievance will be reviewed by the Grievance Advisory Panel within 20 working days after receipt, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of a Grievance, you, or your representative acting upon your behalf, will be notified in writing on or before the 20th working day, and the investigation will be completed within 30 days thereafter. The notice will state specific reasons why additional time is needed for the investigation. A panel of individuals who were not involved in either the initial decision or the first appeal will review your second appeal. If the decision you are asking the

Administrator to review is based on a medical judgment, the committee will include, or will consult with, two or more health care professionals of the same or a similar specialty that would typically manage the medical condition or treatment plan under review.

Within five working days after the investigation is completed, the Grievance Advisory Panel will decide upon the appropriate resolution of the appeal or grievance and the Administrator will notify you in writing, in terms that are clear and specific, of the panel's decision. You, or the person you authorized to represent you in filing the appeal or grievance, will be notified of the resolution of the Grievance within 15 working days after the investigation is completed. Your decision to file an appeal will not affect your rights to any other benefits under your coverage. Your relative, friend, lawyer or other representative may help you with your appeal.

At any time, you can request free copies of all records and other information the Administrator has relevant to your written complaint, including the name of any health care professional the Administrator consulted. To obtain copies, send a written request to the Appeals/Grievance Unit address given above. When your appeal has been received, the Administrator will carefully consider any new information received, as well as all other information the Administrator has about your claim.

12 GENERAL PROVISIONS

Entire Contract

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire agreement between the Plan and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Employer and any and all statements made to the Employer by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of the Plan is authorized to change the form or content of this Benefit Booklet. Changes can only be made through a written authorization, signed by a person authorized to sign on behalf of the Employer.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that he/she, in consultation with his/her Providers, is responsible for determining the treatment appropriate for his/her care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. In this event, the Provider shall have no further responsibility to provide care to you, and the Plan shall have no obligation to have Network Providers available who will render the care.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include, but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under the Plan are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by the Plan as far as is practical under the circumstances, and according to their best judgment.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Regulations issued under HIPAA contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's group health plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. The Administrator of your Employer's Plan has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of the Administrator's Notice, contact the customer service number on the back of your Identification Card.

Coordination of Benefits

Applicability

This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered Dependent has health care coverage under more than one plan. "Plan" and "this plan" are defined here.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

- will not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is defined in "Effect on the Benefits of this Plan" below.

Definitions

"Plan" is any of those that provides benefits or services for, or because of, medical or dental care or treatment:

Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

Coverage under a governmental plan, or coverage required or provided by law. This does not include Medicare Part B or Part D or a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time-to-time). Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"This plan" is the part of the group contract that provides benefits for health care expenses.

"Primary plan/secondary plan": The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan to one or more other plans, and may be a secondary plan as to a different plan(s).

"Allowable expense" means a necessary, reasonable and customary item of expense for health care; including Prescription Drugs, when the items of expense are covered at least in part by one or more plans covering the person for whom the claim is made. "Allowable expense" is limited to like items of expense, such that medical expenses will only coordinate with other medical expenses. The difference between the cost of a private room in a hospital and the cost of a semi-private room in a hospital is not considered an allowable expense under this definition unless the patient's stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, Precertification of admissions or services, and preferred Provider arrangements.

"Claim determination period" means a calendar year. However, it does not include any part of a year during which a person is not covered under this plan, or any part of a year before the date this COB provision or similar provision takes effect.

Order of Benefit Determination Rules

When there is a basis for a claim under this plan and another plan. This plan is a secondary plan that has its benefits determined after those of the other plan, unless:

1. the other plan has rules coordinating its benefits with those of this plan; and
2. both those rules and this plan's rules, outlined below, require that this plan's benefits be determined before those of the other plan.

This plan determines its order of benefits using the first of the following rules which applies:

1. Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that; if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a. secondary to the plan covering the person as a dependent; and
    b. primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
2. Dependent child/parents not separated or divorced. Except as stated in the definition of "Primary plan/secondary plan", when this plan and other plan cover the same child as a dependent of different persons, called parents:
    a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b. If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plans that covered the other parent for a shorter period of time. However, if the other plan does not have the rule described previously and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent child/separated or divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with the custody of the child; and
   c. Finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint custody. If the specific terms of a court degree state that the parents will share joint custody, without stating that one of the parents is responsible for the health Care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in 3. above.

5. Active/inactive employee. The benefits of a plan that covers a person as an employee who is neither laid off nor retired are determined before those of a plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

   a. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

   b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan that covered an employee, member or subscriber longer are determined before those of the plan that covered that person for the shorter term.

Effect on the benefits of this plan

This section applies when, in accordance with the "Order of Benefit Determination Rules" above, this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plans(s) are referred to as the other plans below.

The benefits of this plan will be reduced when the sum of:

- The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
- The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceed those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this plan are reduced as described previously, each benefit is in proportion. It is then charged against any applicable benefit maximum of this plan.

Right to receive and release needed information

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to pay the claim.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, the Plan may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this plan. The Plan will not have to pay that amount again. The term, payment made includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Medicare

Any benefits covered under both the Plan and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under the Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under the Plan, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

Physical Examination

When a claim is pending, the Administrator, on behalf of the Employer, reserves the right to request a Member to be examined by an applicable Provider. This will be requested as often as reasonably required.

Worker's Compensation

The benefits under the Plan are not designed to duplicate benefits that Members are eligible for under the Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under the Plan does not replace or affect any Worker's Compensation coverage requirements.

Other Government Programs

The benefits under the Plan shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payer. If

the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

Subrogation

The Administrator or its designee will provide certain administrative services with regard to subrogation.

Third party liability exists when someone else is legally responsible for the condition of, or injury to, a Member. If a third party is, or may be, liable for the costs of any expenses payable to, or on behalf of, the Member under the Plan, the Member must promptly notify the Employer or Administrator of the claim involving a third party. The Employer or the Administrator will provide the Member with information as to how to proceed.

If a Member is injured and a third party is responsible, the Employer has the right to recover benefits paid under the Plan in connection with the injury or condition from any settlement, including an, award, payment, compromise, verdict or judgment the Member receives from the third party or insurer (including benefits available under the following provisions: Personal Injury Protection, No-Fault, Medical Payments, Liability, Umbrella, Workers' Compensation, Uninsured Motorist, and Underinsured Motorist Coverages). The Employer may pursue the responsible party or the Member to recover the refund. Whether or not the Member sues the responsible party or accepts a settlement or tenders a release, the Employer still has the right to pursue the third party independently.

In addition, the Employer is not obligated to pay benefits for any medical expenses incurred in connection with such injury or condition unless the Member or someone legally qualified and authorized to act for the Member promises the following in writing:

- to include such expenses in any claim made by or for the Member against any party for the injury or condition;
- to reimburse the Employer for any benefit payment the Member receives as a recovery from a settlement with a third party; and
- to cooperate fully with the Employer in asserting its subrogation rights and supply the Employer with any information and forms the Employer may need for this purpose.

In the event the Member fails or refuses to provide an assignment of the right to pursue the responsible party, a form, or a document requested by the Employer, the Employer and the Administrator will be relieved of any and all legal, equitable or contractual obligation for any benefits or Coverage incurred by the Member for such injury or condition.

The Plan's right of recovery shall be a first priority lien against any proceeds recovered by the Member, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages. The Plan shall be entitled to full reimbursement.

No Member or authorized representative shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically, no court costs nor attorney's fees may be deducted from the Plans' recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine."

The Administrator has the discretion to interpret any vague or ambiguous term or provision in favor of the Plan's Subrogation rights.

Right of Reservation

Regardless of any election made by a Member, the coverage under the Plan pays secondary to a No-Fault/Personal Injury Protection policy.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB

provision, the Plan may recover the excess from one or more of:

- The person it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.
- Other catagories of coverages, such as the following: Personal Injury Protection, No-Fault, Medical Payments, Liability, Umbrella, Workers' Compensation, Uninsured Motorist, and Underinsured Motorist Coverages.

Relationship of Parties (Employer-Member Plan)

Neither the Employer nor any Member is the agent or representative of the Plan.

The Employer is responsible for passing information to the Member. For example, if the Plan gives notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to the Plan in a timely manner. If the Employer does not provide the Plan with timely enrollment and termination information, the Plan is not responsible for the payment of Covered Services for Members.

Important Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Booklet and Administrative Services Agreement constitutes a contract solely between the Employer and the Administrator, which is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in its Missouri service area. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, the Administrator is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of the Administrator other than those obligations created under other provisions of this agreement.

Conformity with Law

Any provision of the Plan which is in conflict with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Clerical Error

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or the Plan.

Policies and Procedures

The Plan is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

Under the terms of the Administrative Services Agreement, the Administrator may introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives that may result in the payment of benefits not otherwise specified in this Benefit Booklet. The Administrator reserves the right to discontinue a pilot or test program at any time. The Administrator will provide advance written notice to the Employer of the introduction or termination of any such program.

Waiver

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Benefit Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Additional Benefits

The Plan may cover services and supplies not specifically covered by the Plan. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Grievances and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. The Administrator has complete discretion to interpret the Benefit Booklet. The Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowable Amount. A member may utilize all applicable Complaint & Appeals procedures.

The Employer has the discretion to interpret any vague or ambiguous term or provision in favor of the Plan's Reimbursement rights.

13 DEFINITIONS

If a word or phrase in this Benefit Booklet has a special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card.

Actively At Work – An employee who is capable of carrying out his/her regular job duties and who is present at his/her place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

Administrative Services Agreement – The agreement between the Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employers's group health plan.

Administrator – An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Anthem Blue Cross and Blue Shield. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Authorized Service – A Covered Service that is prescribed by any Provider, other than a Network Provider, which has been authorized in advance by the Administrator, on behalf of the Employer, (except for Emergency Care which may be authorized after the service is rendered) to be paid at the Network level.

Behavioral Health Conditions –

- **Recognized Mental Illness** – Those conditions classified as mental disorders in

the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

- **Substance Abuse** – The psychological or physiological dependence upon or abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and the impairment of social or occupational role functioning or both.

Behavioral Health Treatments -

- **Episode** – A distinct course of Substance Abuse treatment separated by at least 30 days without treatment.
- **Facility-Based Treatment Program** – A program certified by the Department of Mental Health or accredited by a nationally recognized organization, involving structured, intensive treatment for a Recognized Mental Illness or Substance Abuse. Such a program includes day or evening treatment, partial hospitalization, intensive Outpatient programs and residential treatment programs.
- **Medical Detoxification** – Hospital Inpatient or residential medical care to ameliorate acute medical conditions associated with Substance Abuse.
- **Social Setting Detoxification**. A program in a supportive non-Hospital setting designed to achieve detoxification without the use of drugs or other medical intervention, to establish a plan of treatment and to provide for medical referral when necessary.

Benefit Booklet – This summary of the terms of your health benefits.

Benefit Period – The length of time that the Plan will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.

Benefit Period Maximum – The maximum that the Plan will pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new Drug for a certain number of years.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services indicated in the Schedule of Benefits that you must pay. Coinsurance normally applies after the Deductible, if applicable, that you are required to pay. See the Schedule of Benefits for any exceptions. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible or Coinsurance that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or amount charged by the Provider.

Covered Services - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under the Plan.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by the Administrator, on behalf of the Employer, if such Prior Authorization is required in this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and bone marrow / stem cell transplant / transfusion as determined by the Administrator, on behalf of the Employer, including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloblative therapy.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before the Plan will pay for those Covered Services in each Benefit Period.

Dependent – A member of the Subscriber's family who is covered under the Plan, as described in the "Eligibility and Enrollment" section.

Effective Date – The date that a Subscriber's coverage begins under the Plan. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who meets the Employer's requirements and is entitled to apply to be a Subscriber.

Emergency – An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity that the absence of immediate medical attention could be reasonably expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- place the person's health in significant jeopardy;
- result in serious impairment to a bodily function;
- result in serious dysfunction of any bodily organ or part;
- result in inadequately controlled pain; or
- with respect to a pregnant woman who is having contractions:
    1. believe that there is inadequate time to effect a safe transfer to another Hospital before delivery; or

2. believe that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Care - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law, that may include, but will not be limited to, services provided in a licensed Hospital's emergency facility, that are needed to evaluate or Stabilize an individual in an Emergency.

Employer – The legal entity contracting with the Administrator for administration of group health care benefits.

Enrollment Date – The day the Employer or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or

- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

The Plan may consult with professional peer review committees or other appropriate sources for recommendations.

Family Coverage – Coverage for the Subscriber and all eligible Dependents.

Fees – The periodic charges that must be paid by you and/or the Employer to maintain benefits under the Plan.

Formulary - The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Grievance Advisory Panel - A panel consisting of other enrollees; the Administrator's representatives who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and, where the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

Identification Card / ID Card – A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

Late Enrollee – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under the Plan and who did not qualify for Special Enrollment.

Lifetime Maximum – The maximum dollar amount the Plan will pay for Covered Services during your lifetime.

Mail Service – The Plan's Prescription Management program which offers you a convenient means of obtaining maintenance

medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Administrator, and sent directly to your home.

Maximum Allowable Amount – The maximum amount that the Plan will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity - Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. The Plan may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Fees payment; Members are sometimes called "you" or "your" in this Benefit Booklet.

Network Provider - A Provider who has entered into a contractual agreement or is being used by the Administrator, or another organization, which has an agreement with the Administrator, to provide Covered Services and certain administration functions for the Network associated with the Plan.

Network Transplant Provider – A Provider that has been designated as a "center of excellence" by the Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed Drug product but new manufacturer: a product that duplicates another firm's already marketed Drug product (same active ingredient, formulation, or combination);
- Already marketed Drug product, but new use: a new use for a Drug product already marketed by the same or a different firm; or
- Newly introduced generic medication: generic medications contain the same active ingredient as their counterpart brand-named medications.

Non-Network Provider - A Provider who has not entered into a contractual agreement with the Administrator for the Network associated with the Plan. Providers who have not contracted or affiliated with the Plan's designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Non-Network Transplant Provider - Any Provider that has **NOT** been designated as a "center of excellence" by the Administrator or has not been selected to participate as a Network Transplant Provider by a designee.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; See "Eligibility and Enrollment" section for more information.

Out-of-Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out-of-Pocket Limit is reached for a Member and/or family, then no additional Deductibles and Coinsurance are required for that person and/or family unless otherwise specified in this Benefit Booklet and/or the Schedule of Benefits.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Pharmacy and Therapeutics (P&T) Committee – A committee of Physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain Drugs and/or therapeutic categories will be approved for coverage.

Plan – The group health benefit plan provided by the Employer and explained in this Benefit Booklet.

Pre-Existing Condition – A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before your Enrollment Date. Pregnancy and domestic violence are not considered to be Pre-Existing Conditions. Genetic information may not be used to pre-determine a future condition, it must be based on an actual diagnosis.

Prescription Order – A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug – A medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under the Plan.

Primary Care Physician ("PCP") – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID Card.

- **Alternative Care Facility** - A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:

  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
  2. Surgery
  3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:

  1. is licensed as such, where required;
  2. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. does not provide Inpatient accommodations; and
  5. is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Certified Advance Registered Nurse Practitioner**

- **Certified Nurse Midwife** - When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - When services are performed in collaboration with a Physician and billed by a certified facility or Hospital.

- **Certified Surgical Assistant**

- **Chiropractor**

- **Community Mental Health Center** - A legal entity certified by the Department of Mental Health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.

- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility** - A facility that mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:

  1. provides skilled nursing and other services on a visiting basis in the Member's home; and
  2. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Facility** - A facility which provides a combination of:

  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances

  in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

1. provides room and board and nursing care for its patients;
2. has a staff with one or more Physicians available at all times;
3. provides 24 hour nursing service by or under the supervision of graduate Registered Nurses on call or on duty;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care
2. rest care
3. extended care
4. convalescent care
5. care of the aged
6. Custodial Care
7. educational care
8. treatment of mental illness
9. treatment of alcohol or drug abuse

- **Laboratory (Clinical)**
- **Licensed Practical Nurse** – When services are supervised and billed for by an employer Physician.
- **Licensed Mental Health Professional** – A licensed Physician specializing in the treatment of Mental Illness and/or Substance Abuse, a licensed Psychologist, a licensed clinical Social Worker or a Licensed Professional Counselor.
- **Licensed Professional Counselors**
- **Occupational Therapist**
- **Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist**
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or ophthalmologist (eye and sight specialist).
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Registered Nurse First Assistant** - When services are supervised and billed for by an employer Physician.
- **Registered Nurse** - When services are supervised and billed for by an employer Physician.
- **Registered Nurse Practitioner**
- **Regulated Physician's Assistant** - When services are supervised and billed for by an employer Physician.
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Respiratory Therapist (Certified)**
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or domiciliary care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Speech Therapist**
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
- **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Service Area – The geographical area, designated by the Plan, in which the program described in this Benefit Booklet is available.

Single Coverage – Coverage that is limited to the Subscriber only.

Special Enrollment – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

Specialty Care Physician (SCP) - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Stabilize - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor – The Administrator and/or the Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Administrator's or Employer's behalf.

Subscriber - An employee or member of the Employer who is eligible to receive benefits under the Plan.

Therapy Services – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

Total Disability (or Totally Disabled) – A Subscriber or a Dependent who had been actively working is considered Totally Disabled if the Member is unable to perform the material and substantial duties of his or her occupation for a period of at least 12 months.

A retiree or a Dependent who had not been actively working is considered Totally Disabled if he or she is unable, because of an illness or injury, to perform the usual and ordinary activities of a person of like age. (In any of these situations, the disability may be either permanent or temporary.)

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Group Name:	Qinetiq North America
Group Identification Number:	00169397
Subgroup Identification Number:	0000

Mail to subscriber.

FMO14-MB GRGR

Mary T Dowty
410 Allen Dr
Merritt Island FL 32952

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